IMPROVING SUICIDE CARE IN BC:

A Dialogue with People with Lived and Living Experience (PWLLE)

September 27, 2022 at the Morris J. Wosk Centre for Dialogue

Canadian Mental Health Association
British Columbia
Mental health for all

BRITISH COLUMBIA
Supported by the Province of British Columbia

BACKGROUND

SUMMARY OF FUNDING INITIATIVE

In Canada, suicide is the ninth leading cause of death overall,[1] with an average of more than **10 Canadians dying by suicide every day**. In the Province of British Columbia, **over 580 individuals are lost to suicide annually**.[2] Further, for every person lost to suicide, many more experience mental health crises that increase the risk of suicide. Suicide is a public health issue.

> **Thank you for this event. I felt that you all crated such a safe, welcoming space, ensuring that the voices of people with lived and living experience where amplified and heard**
> ***– Event participant***

In September 2022, the Province of British Columbia announced* its commitment to facilitate a system-wide transformation in how suicide risk and care are addressed and managed. To this end, the Ministry of Mental Health and Addictions has invested $2 million to improve the quality of care provided to individuals experiencing mental health crises, thoughts of suicide, and/or suicide attempts. This investment is being stewarded by the Canadian Mental Health Association, BC Division (CMHA BC) who is convening and collaborating with regional health authorities to support dedicated quality improvement efforts. At the same time, a provincial suicide framework is being developed to promote best practices and consistency in the quality of suicide care delivered in emergency departments, acute-care psychiatry, and specialized mental health and substance use outpatient settings.

SUMMARY OF EVENT

Improving Suicide Care in BC: A Dialogue with People with Lived and Living Experience

Ensuring thoughtful stakeholder engagement is crucial to the success of the Suicide Care Initiative. As a first step in stakeholder consultation, CMHA BC hosted a first-ever of its kind event "Improving Suicide Care in BC: A Dialogue with People with Lived and Living Experience." This event took place on September 27th, 2022 at the Morris J. Wosk Centre for Dialogue in Vancouver, BC, and brought together individuals from all across the province. See *Appendix 1* for a list of participating organizations.

The event aimed to provide PWLLE** with an opportunity to share their experiences and perspectives and engage in a dialogue with managers from regional health authorities, along with representatives from government and non-government partners. This report summarizes the key themes and recommendations to consider that emerged from the dialogues. The intent is to ensure that perspectives of and suggestions from PWLLE are considered and applied to the quality improvement and system change efforts that are supported by the Suicide Care Initiative funding.

KEY THEMES

To foster dialogue among stakeholders, CMHA BC organized a series of speaker panels and breakout discussion groups focused on key topics. Discussions centered around experiences of care, with a specific focus on the varying steps of the hospitalization process. This included discussions focussed

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* news.gov.bc.ca/releases/2022MMHA0057-001353

** CMHA BC recruited 17 individuals to attend this event as PWLLE. Considerations were made to ensure diverse representation including diversity of in gender identity; culture; race; geographic location; and age. CMHA BC recognizes though that more consultation is required with PWLLE, and that this group is not necessarily representative of all British Columbians. Further, CMHA BC acknowledges that many individuals attending this event as a function of their jobs also brought lived and living experience to their participation. Findings in this summary report reflect the views of those who participated in the event.

on experiences with: intake processes; the emergency department; admission; in-patient care; discharge; follow-up and culture and identity. The discussions led to the sharing of numerous valuable perspectives, which can be summarized into the following five key areas for suggested improvements:

1. RELATIONSHIP BETWEEN CLIENT & SERVICE PROVIDERS

Participants reported that relationships between the client and the service provider was a critical aspect of the care experience for people in crisis. When meaningful, empathetic, and respectful relationships were formed between clients and their providers, clients reported better outcomes. The sooner these relationships were established, the more positive the experience. When discussing relationships, the following key points were highlighted:

- **Some clients reported experiencing instances of negative interactions with service providers, which negatively impacted their care experience.** Some examples include: not being taken seriously; being left feeling like a burden for accessing care; overhearing stigmatizing language being used to describe clients; experiencing providers making biased or stigmatizing assumptions about clients (especially related to culture, gender, orientation, etc.).
    - Participants reported that, most often, perceived structural/systemic **stigma was a key contributor to negative experiences** of relationships with service providers.
- **Participants from all backgrounds expressed empathy for the level of burnout and corresponding empathy fatigue that is being experienced by healthcare providers.** There was overwhelming acknowledgement of how current labour conditions are contributing to these relationship breakdowns.

Proposed Recommendations:

- Continue to deliver and expand upon delivery of **sensitivity training for hospital staff with a specific focus on empathy, culture, and identity considerations.** Consider involving PWLLE in the development and delivery of this training.
- **Implement, or expand upon existing, peer support opportunities.** Many participants felt that being understood by, and in the company of, a peer was incredibly beneficial. Peer support could be implemented at any part of the patient journey (intake, admission, discharge).
- Explore and implement ways to **alleviate healthcare worker burnout** to resolve resulting empathy fatigue**.**
- Assess and **address instances of structural stigma** using relevant tools and best practices.

2. THE NEED FOR PERSON-CENTERED CARE & PATIENT AUTONOMY/AGENCY

Participants shared how having agency, autonomy, and a clear understanding of the care they were being given, had immensely positive impacts on treatment outcomes. During times when participants did not feel heard or understood, and/or did not have a clear understanding of their care plan, they reported feeling dehumanized and had an increased sense of hopelessness. Specifically, discussions centered around the following points:

- **Trauma-informed care, including consent and respect for boundaries, is critical in all patient/provider interactions.** This was especially pertinent when clothing items were required to be removed and/or when items were being placed on the patient's body (e.g., monitors).
- **Participants expressed the importance of person-centered care and "meeting clients where they are at."** This means, among many things: helping to provide clients with a full understanding of their treatment plan(s) and/or options; communicating clearly about what is being done in the moment;

allowing clients choice and agency over their treatment plan whenever possible; understanding that treatment will look different for each person; and allowing for and respecting self-advocacy.
    - Participants mentioned that often culture and/or spirituality is an important component of healing for some clients; however, this is often missed or dismissed in treatment plans. There is a strong **desire for culture and/or spirituality to be recognized in clients' treatment when desired by the client.**

Proposed Recommendations:

n.b. the proposed action items for this topic area are the same as the 3 listed for item 1.

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3. IMPROVEMENTS TO THE CARE SETTING

There was a general sense among participants that not all hospitals are set up in ways that are conducive to providing exceptional mental health treatment. This theme was especially prevalent when discussing emergency departments. Participants felt that care facilities could benefit from some key changes to their physical space, and/or from moving suicide care that does not involve imminent risk to life into a separate facility. Discussion topics included:

- **The use of seclusion rooms, especially when paired with sedation, left clients feeling afraid and without the ability to self-advocate.**
- **The hospital ambiance (flashing lights, repetitive sounds, loud voices) led some clients to feeling more agitated.**
- **Due to space constraints, clients have been left in areas of the hospital that felt unsafe or uncomfortable (e.g., alone in dark hallways).**

Proposed Recommendations:

- Implement provincial policies and safeguards around how seclusion rooms are used and when. **Seclusion rooms should be avoided unless absolutely necessary.**
- Create or **set aside a quiet space where clients can go to sit voluntarily to escape the general hospital ambience.** This space could house the peer support services. It should be designed to be inviting, and comforting, without loud sounds and flashing lights.
- Longer-term, **there should be consideration for moving suicide care outside of the primary hospital setting for care where imminent threat to life is not present.** This could look like having a mental health centre connected to the hospital that is set up specifically to provide holistic mental health care including both clinical and non-clinical interventions.

4. POST-DISCHARGE FOLLOW-UP

Transition and follow-up support post-discharge was one of the major areas where participants felt improvements could be made. Participants shared that there is often little to no follow-up post-hospitalization, despite the fact that there is heightened suicide risk following discharge.[4] Because clients often are not linked to further support, participants report ending up in repeating cycles of returned hospitalization. Specific concerns discussed include:

- **Lack of successful connection to follow-up support:** participants either did not receive referrals to additional support, or were unable to access follow-up support due to long wait times, inability to system navigate, confusion around referral process, etc.
- **Lack of communication and continuity of care between service providers:** Participants report witnessing communication breakdowns between service providers. If they were connected to external support, often, those service providers did not have access to pertinent clinical history. This posed a barrier to treatment, and occasionally required clients to relive traumatic experiences.
- **Heavy reliance on family, loved ones, and caregivers for follow up support, without matching training, preparation, or support for these individuals:** Participants report that often family, loved ones, and caregivers were heavily relied on for post-discharge care. Often though, these folks do not receive the appropriate treatment, training, or support in order to appropriately care for the individual who has just returned from hospital.

> **The panel of folks with lived and living experience was incredible. It is so important to have these voices. It makes us driven to implement strategies rather than things always being top down.**
> ***– Event participant***

Proposed Recommendations:

- With patient consent, **involve family, loved ones and/or caregivers in discharge planning.** Ensure that folks responsible for post-discharge care receive appropriate training, information, and resources.
    - **Invest in training and support for caregivers who are caring for a loved one experiencing thoughts of suicide.**
- **Partner with BC Crisis Line Network to instate a phone- or text-based follow up system for clients post-discharge.** This has been done in other communities and shown to be successful at reducing future suicide risk.[5] World Health Organization protocol describes one way this can be done.
- **Improve communication between hospital staff and follow-up referral partners t**hrough information sharing agreements for clients at risk of suicide.
- **Where they do not exist already, consider creating standardized discharge "packages"** for clients that include things like: resource lists detailing where clients can access future support; greeting cards with affirmative statements; a copy of the clients' co-created safety plan; general informational brochures on suicide.

5. POLICE INVOLVEMENT

Although outside of the scope of this funding initiative, it is worth mentioning that the theme of police involvement in mental health-related hospitalization came up frequently. Participants expressed that they did not feel as though police, in general, are well equipped to handle mental health crises. Specific themes of these discussions included:

- **Presence of police contributed to clients' feelings of shame** around their mental health crisis and/or mental illness. Participants described these experiences leaving them feeling like "criminals."
- **Police sometimes use intervention tactics that further escalated the situation and/or led to further harm or traumatization.** Participants felt that, at times, police presence increased their risk of harm. |

Proposed Recommendations:

- **Continue the investment in – and development of – Peer Assisted Care Teams (PACT).** These multi-disciplinary community-led crisis teams pair a mental health professional with a peer support worker and offer a compassionate alternative to police involvement.
- **Continue to train police and RCMP officers in non-violent communication and crisis de-escalation.** In addition to providing alternatives to police-intervention, it is important that officers who are responding and witness individuals in crisis have a better understanding and training on how to engage safely with individuals.

CALL TO ACTION

This provincial dialogue, the first of its kind, focused on how the formal system responds to individuals experiencing suicidal crises, was a meaningful experience for all who attended. Participant evaluation results indicated that they felt safe and respected, that the dialogues were well balanced, and felt as though they will have an impact on the quality of care for people in crisis.

> **I appreciated that people with lived experience were centered throughout the event.**
> ***– Event participant***

The success of the event can be largely attributed to the courage and honesty of the several individuals in attendance who had previously sought help during a mental health crisis and who willingly shared their experiences interacting with health care services. The messages and themes expressed by people with lived experience revealed significant shortcomings in person-centered care, inadequate recognition of trauma, culture, and identity, failures in the relationship between practitioners and clients, safety concerns, and gaps in effective management of suicide risk during after a care encounter. For those seeking help, these issues, among a myriad of other unique concerns, contributed to a sense that their need for help was less legitimate than physical health complaints. That this perceived and real inequity continues to be experienced by people with mental illness reflects the longstanding structural stigma within the health care system.

The participation of health authorities, government, and non-government agencies in the provincial dialogue showcased a desire for collaborative action to address stigma and gaps in care. The value of ensuring those who need, and receive, services during a crisis have a voice in the planning and delivery of mental health care in BC was resoundingly endorsed. Attendees with a responsibility for planning and delivery of services left with a commitment to explore suggested actions for system improvement.

As an organization, CMHA BC is committed to continually involving key stakeholderss, particularly PWLLE, in this funding initiative and other efforts that respond to the service needs of people with mental health and substance use challenges.

For more information about this initiative etc. please connect with us at Canadian Mental Health Association BC at public.policy@cmha.bc.ca or visit us at cmha.bc.ca.

APPENDIX 1. LIST OF PARTICIPATING GROUPS AND ORGANIZATIONS

1. Persons with lived/living experience
2. Island Health
3. Northern Health
4. Interior Health
5. Fraser Health
6. Vancouver Coastal Health
7. Crisis Centre BC
8. Ministry of Children and Family Development
9. Ministry of Health
10. Ministry of Mental Health and Addictions
11. Canadian Mental Health Association, BC Division
12. Canadian Mental Health Association, North West Vancouver Branch
13. Office of the Ombudsperson for BC
14. Provincial Health Services Association
15. BC Patient Safety & Quality Council
16. Canadian Mental Health Association, Vernon & District Branch
17. Prince George Native Friendship Centre
18. Health Justice BC
19. Vancouver Island Crisis Society

ENDNOTES

[1] Canada, P. H. A. of. (2022, September 2). *Suicide in Canada*. Government of Canada. www.canada.ca/en/public-health/services/suicide-prevention/suicide-canada.

[2] BC Coroner's Service (2022, May 20). *Suicide Knowledge Update to December 2021*. Government of British Columbia. www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/suicide_knowledge_update.pdf.

[3] Mental Health Commission of Canada (2022, April 21). *Structural stigma*. Mental Health Commission of Canada. mentalhealthcommission.ca/structural-stigma.

[4] Forte, A., Buscajoni, A., Fiorillo, A., Pompili, M., & Baldessarini, R. J. (2019). Suicidal Risk Following Hospital Discharge: A Review. *Harvard review of psychiatry, 27*(4), 209–216. doi.org/10.1097/HRP.0000000000000222

[5] Skef, Suzan MD. (2019) Brief intervention and contact (BIC) program is effective for suicide prevention. *Evidence-Based Practice. 22*(1), 4-5. doi.org/10.1097/EBP.0000000000000196